#### [COMPANY NAME]

Outline of Medicare	Sunnlement	Coverage-0	Cover Page:	1 of 2
Outilite of Medicale	Supplement	COVERAGE-C	JUVEL FAUE.	1012

Benefit Plans	[insert letters of plans being offered

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state.

#### See Outlines of Coverage sections for details about ALL plans

#### Basic Benefits for Plans A - J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

Α	В	С	D	Е	F F*	G	Н	I	J J*
Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic
Benefits	Benefits	Benefits	Benefits	Benefits	Benefits	Benefits	Benefits	Benefits	Benefits
		Skilled							
		Nursing							
		Facility							
		Coinsurance							
	Part A	Part A	Part A	Part A	Part A	Part A	Part A	Part A	Part A
	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
		Part B			Part B				Part B
		Deductible			Deductible				Deductible
					Part B	Part B		Part B	Part B
					Excess	Excess		Excess	Excess
					(100%)	(80%)		(100%)	(100%)
		Foreign							
		Travel							
		Emergency							
			At-Home			At-Home		At-Home	At-Home
			Recovery			Recovery		Recovery	Recovery
				Preventive					Preventive
				Care NOT					Care NOT
				covered by					covered by
				Medicare					Medicare

<sup>\*</sup> Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [\$1730] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [\$1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

# [COMPANY NAME] Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	<ul> <li>100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End</li> <li>50% Hospice cost-sharing</li> <li>50% of Medicare-eligible expenses for the first three pints of blood</li> <li>50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services</li> </ul>	<ul> <li>100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End</li> <li>75% Hospice cost-sharing</li> <li>75% of Medicare-eligible expenses for the first three pints of blood</li> <li>75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services</li> </ul>
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$[4000] Out of Pocket Annual Limit***	\$[2000] Out of Pocket Annual Limit***

<sup>\*\*</sup> Plans K and L provide for different cost-sharing for items and services than Plans A – J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

See Outlines of Coverage for details and exceptions.

<sup>\*\*\*</sup>The out-of-pocket annual limit will increase each year for inflation.

#### **PREMIUM INFORMATION** [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

#### **DISCLOSURES** [Boldface Type]

Use this outline to compare benefits and premiums among policies.

#### **READ YOUR POLICY VERY CAREFULLY** [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

#### **RIGHT TO RETURN POLICY** [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

#### **POLICY REPLACEMENT** [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

#### **NOTICE** [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

#### **COMPLETE ANSWERS ARE VERY IMPORTANT** [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

#### **PLAN A**

#### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime	All but \$[912] All but \$[228] a day	\$0 \$[228] a day	\$[912](Part A deductible) \$0
reserve days  —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility Within 30 days after leaving the hospital First 20 days 21st thru 100th day	All approved amounts All but \$[114] a day	\$0 \$0	\$0 Up to \$[114] a day
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### **PLAN A**

# MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL			
TREATMENT, such as Physi-			
cian's services, inpatient and			
outpatient medical and surgical services and supplies, physical			
and speech therapy, diagnostic			
tests, durable medical equipment,			
First \$[100] of Medicare			
Approved Amounts*	\$0	\$0	\$[100] (Part B
Remainder of Medicare			deductible)
Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare Approved	<b>CO</b>	<b>CO</b>	All costs
Amounts) BLOOD	\$0	\$0	All costs
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare Approved	, -		, -
Amounts*	\$0	\$0	\$[100] (Part B
Remainder of Medicare Approved			deductible)
Amounts	80%	20%	\$0
CLINICAL LABORATORY			* -
SERVICES—TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

#### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED			
SERVICES			
—Medically necessary skilled			
care services and medical			
supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[100] of Medicare			
Approved Amounts*	\$0	\$0	\$[100] (Part B
			deductible)
Remainder of Medicare			
Approved Amounts	80%	20%	\$0

#### **PLAN B**

#### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61 <sup>st</sup> thru 90th day 91 <sup>st</sup> day and after: —While using 60 lifetime	All but \$[912] All but \$[228] a day	\$[912](Part A deductible) \$[228] a day	\$0 \$0
reserve days —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[114] a day \$0	\$0 \$0 \$0	\$0 Up to \$[114] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### **PLAN B**

# MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$[100] of Medicare			
Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare	Conorally 900/	Conorally 200/	\$0
Approved Amounts Part B Excess Charges	Generally 80%	Generally 20%	\$0
(Above Medicare Approved			
Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare			
Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare			,
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

#### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED   SERVICES			
—Medically necessary skilled			
care services and medical	1000/	<b>*</b> 0	ФО.
supplies  —Durable medical equipment	100%	\$0	\$0
First \$[100] of Medicare			
Approved Amounts*	\$0	\$0	\$[100] (Part B
Description of Market			deductible)
Remainder of Medicare			
Approved Amounts	80%	20%	\$0

#### **PLAN C**

#### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61 <sup>st</sup> thru 90th day 91 <sup>st</sup> day and after: —While using 60 lifetime	All but \$[912] All but \$[228] a day	\$[912](Part A deductible) \$[228] a day	\$0 \$0
reserve days —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100th day 101st day and after	All approved amounts All but \$[114] a day \$0	\$0 Up to \$[114] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### **PLAN C**

## MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY		
MEDICAL EXPENSES—					
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL					
TREATMENT, such as physi-					
cian's services, inpatient and					
outpatient medical and surgical					
services and supplies, physical and speech therapy, diagnostic					
tests, durable medical equipment,					
First \$[100] of Medicare					
Approved Amounts*	\$0	\$[100] (Bort B doductible)	\$0		
Approved Amounts	Φ0	\$[100] (Part B deductible)	\$0		
Remainder of Medicare					
Approved Amounts	Generally 80%	Generally 20%	\$0		
Part B Excess Charges					
(Above Medicare Approved					
Amounts)	\$0	\$0	All costs		
BLOOD					
First 3 pints	\$0	All costs	\$0		
Next \$[100] of Medicare Approved					
Amounts*	\$0	\$[100] (Part B deductible)	\$0		
Remainder of Medicare Approved					
Amounts	80%	20%	\$0		
CLINICAL LABORATORY					
SERVICES—TESTS FOR	4000/				
DIAGNOSTIC SERVICES	100%	\$0	\$0		
	PARTS A	7 & B	T		
HOME HEALTH CARE					
MEDICARE APPROVED					
SERVICES					
—Medically necessary skilled					
care services and medical	4000/	<b>60</b>	( C		
supplies	100%	\$0	\$0		
—Durable medical equipment					
First \$[100] of Medicare Approved Amounts*	40	#14001 (Dort D dod	¢0		
Remainder of Medicare	\$0	\$[100] (Part B deductible)	\$0		
	900/	20%	0.0		
Approved Amounts	80%	OVERED BY MEDICARE	\$0		
OTHER BENEFITS—NOT COVERED BY MEDICARE					
FOREIGN TRAVEL— NOT COVERED BY MEDICARE					
Medically necessary emergency					
care services beginning during the					
first 60 days of each trip outside					
the USA					
First \$250 each calendar year	\$0	\$0	\$250		
Remainder of Charges	\$0	80% to a lifetime maxi-	20% and amounts over the		
Tremainder of Onlarges	Ψ0	mum benefit of \$50,000	\$50,000 lifetime maximum		
	1	muni beneni di \$50,000	ψου,υυυ incline maximum		

#### **PLAN D**

#### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime	All but \$[912] All but \$[228] a day	\$[912] (Part A deductible) \$[228] a day	\$0 \$0
reserve days —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day \$0	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100th day 101st day and after	All approved amounts All but \$[114] a day \$0	\$0 Up to \$[114] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### **PLAN D**

#### MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—		LANTAIO	100171
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
TREATMENT, such as physi-			
cian's services, inpatient and			
outpatient medical and surgical			
services and supplies, physical			
and speech therapy, diagnostic			
tests, durable medical equipment,			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B
Approved Amounts	ΨΟ	ΨΟ	deductible)
Remainder of Medicare			
Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare Approved			
Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare	\$0	\$0	¢(1001 /Dort D
Approved Amounts*	φυ	Φ0	\$[100] (Part B deductible)
Remainder of Medicare			deddelible)
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

#### **PLAN D**

#### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled			
care services and medical supplies —Durable medical equipment First \$[100] of Medicare	100%	\$0	\$0
Approved Amounts*  Remainder of Medicare	\$0	\$0	\$[100] (Part B deductible)
Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit Number of visits covered (Must be received within 8 weeks of last	\$0	Actual charges to \$40 a visit	Balance
Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

## OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

#### **PLAN E**

#### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61 <sup>st</sup> thru 90th day 91 <sup>st</sup> day and after: —While using 60 lifetime	All but \$[912] All but \$[228] a day	\$[912] (Part A deductible) \$[228] a day	\$0 \$0
reserve days —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101st day and after	All approved amounts All but \$[114] a day \$0	\$0 Up to \$[114] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### **PLAN E**

#### MEDICARE (PART B)—MEDICAL SERVICES—PER BENEFIT PERIOD

\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare			
Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts*	\$0 \$0	All costs	\$0 \$[100] (Part B
Remainder of Medicare Approved Amounts	80%	20%	deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

#### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled			
care services and medical			
supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[100] of Medicare			
Approved Amounts*	\$0	\$0	\$[100] (Part B
Remainder of Medicare			deductible)
Approved Amounts	80%	20%	\$0

PLAN E
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency			
care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
*PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE			
Some annual physical and preventive tests and services			
administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

<sup>\*</sup>Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

#### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1730] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

		[AFTER YOU PAY \$[1730] DEDUCTIBLE,**]	[IN ADDITION TO \$[1730] DEDUCTIBLE,**]
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and miscellaneous			
services and supplies			
First 60 days	All but \$[912]	\$[912] (Part A deductible)	\$0
61st thru 90 <sup>th</sup> day	All but \$[228] a day	\$[228] a day	\$0
91st day and after:			
While using 60	All but CIAFOL a day	#14501 a day	фO
Lifetime reserve days Once lifetime reserve days	All but \$[456] a day	\$[456] a day	\$0
Are used:			
Additional 365 days	\$0	100% of Medicare	\$0***
Additional 303 days	φ0	eligible expenses	φυ
Beyond the additional		cligible experises	
365 days	\$0	\$0	All costs
SKILLED NURSING	40	45	7 111 00010
FACILITY CARE*			
You must meet Medicare's			
requirements, including having been			
in a hospital for at least 3 days and			
entered a Medicare-approved facility			
within 30 days after leaving the			
hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[114] a day	Up to \$[114] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	All by the second section is		
Available as long as your doctor	All but very limited coinsur-		
certifies you are terminally ill and you	ance for out-patient drugs	<b>#</b> 0	Dalamas
elect to receive these services	and inpatient respite care	\$0	Balance

<sup>\*\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1730] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

		[AFTER YOU PAY \$[1730]	[IN ADDITION TO \$[1730]
		DEDUCTIBLE,**]	DEDUCTIBLE,**]
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -			
IN OR OUT OF THE			
HOSPITAL AND OUTPATIENT			
HOSPITAL TREATMENT,			
Such as physician's			
Services, inpatient and			
Outpatient medical and			
Surgical services and			
Supplies, physical and			
Speech therapy,			
Diagnostic tests,			
Durable medical			
Equipment,			
First \$[100] of Medicare	<b>#</b> 0	\$14001 (Doot D	фО
Approved amounts*	\$0	\$[100] (Part B deductible)	\$0
Remainder of Medicare		deductible)	
Approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges	Concrany 6676	Concrany 20 /0	Ψ
(Above Medicare Approved			
Amounts)	\$0	100%	\$0
BLOOD	, , , , , , , , , , , , , , , , , , ,		Ψ.
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare		1 55555	7 -
Approved amounts*	\$0	\$[100] (Part B	\$0
		deductible)	,
Remainder of Medicare		,	
Approved amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—TESTS			
FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

#### PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1730] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1730] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE	INEDIGARE LATO	ILANIAIO	100171
MEDICARE APPROVED			
SERVICES			
—Medically necessary skilled			
care services and medical			
supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[100] of			
Medicare approved	ФО.	#[400] /D+ D	00
Amounts*	\$0	\$[100] (Part B	\$0
Remainder of		deductible)	
Medicare approved			
Amounts	80%	20%	\$0

#### OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1730] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1730] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL -			
NOT COVERED BY MEDICARE			
Medically necessary			
Emergency care services			
Beginning during the			
first 60 days of each			
trip outside the USA			
First \$250 each			
calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50.000	20% and amounts over the \$50,000 lifetime maximum

#### **PLAN G**

#### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime	All but \$[912] All but \$[228] a day	\$[912] (Part A deductible) \$[228] a day	\$0 \$0
reserve days —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100th day 101st day and after	All approved amounts All but \$[114] a day \$0	\$0 Up to \$[114] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### **PLAN G**

#### MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR			
OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL			
TREATMENT, such as physi-			
cian's services, inpatient and			
outpatient medical and surgical			
services and supplies, physical			
and speech therapy, diagnostic			
tests, durable medical equipment, First \$[100] of Medicare			
Approved Amounts*	\$0	\$0	\$[100] (Part B
			deductible)
Remainder of Medicare			
Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare Approved	<b>C</b> O	000/	200/
Amounts) BLOOD	\$0	80%	20%
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare Approved	ΨΟ	All Costs	Ψ0
Amounts*	\$0	\$0	\$[100] (Part B
			deductible)
Remainder of Medicare Approved			
Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—TESTS FOR	100%	60	<b>60</b>
DIAGNOSTIC SERVICES	100%	\$0	(5.5.4 (5.5.5.4)

#### **PLAN G**

#### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled			
care services and medical supplies —Durable medical equipment First \$[100] of Medicare	100%	\$0	\$0
Approved Amounts*  Remainder of Medicare	\$0	\$0	\$[100] (Part B deductible)
Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit  —Number of visits covered (Must be received within 8 weeks of last Medicare	\$0	Actual charges to \$40 a visit	Balance
Approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

#### OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maxi- mum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

#### **PLAN H**

#### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61 <sup>st</sup> thru 90th day 91 <sup>st</sup> day and after: —While using 60 lifetime	All but \$[912] All but \$[228] a day	\$[912] (Part A deductible) \$[228] a day	\$0 \$0
reserve days —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100th day 101st day and after	All approved amounts All but \$[114] a day \$0	\$0 Up to \$[114] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>\*\*</sup> **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### **PLAN H**

# MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR			
OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL			
TREATMENT, such as Physi-			
cian's services, inpatient and			
outpatient medical and surgical			
services and supplies, physical			
and speech therapy, diagnostic tests, durable medical equipment,			
First \$[100] of Medicare			
Approved Amounts*	\$0	\$0	\$[100] (Part B
			deductible)
Remainder of Medicare			
Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare		0.04	A 11 O 1
Approved Amounts)	\$0	0%	All Costs
BLOOD	<b>C</b> O	All costs	ФО.
First 3 pints Next \$[100] of Medicare Approved	\$0	All costs	\$0
Amounts*	\$0	\$0	\$[100] (Part B
Amounts	ΨΟ	Ψ0	deductible)
Remainder of Medicare Approved			
Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

#### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled			
care services and medical supplies —Durable medical equipment First \$[100] of Medicare	100%	\$0	\$0
Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

# PLAN H OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime max- imum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

#### **PLAN I**

#### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61 <sup>st</sup> thru 90th day 91 <sup>st</sup> day and after: —While using 60 lifetime	All but \$[912] All but \$[228] a day	\$[912] (Part A deductible) \$[228] a day	\$0 \$0
reserve days —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100th day 101st day and after	All approved amounts All but \$[114] a day \$0	\$0 Up to \$[114] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### **PLAN I**

# MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

		YOU PAY
0	\$0	\$[100] (Part B
		deductible)
Generally 80%	Generally 20%	\$0
20110141119 2070	20.10.uy 2070	<b>4</b> •
\$O	100%	\$0
60	All costs	\$0
60	\$0	\$[100] (Part B
200/	200/	deductible)
5U%	ZU%	\$0
100%	\$0	\$0
<u>3</u>	Generally 80%	Generally 80%  Generally 20%  100%  All costs  \$0  \$0  20%

#### **PLAN I**

#### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled			
care services and medical supplies —Durable medical equipment First \$[100] of Medicare	100%	\$0	\$0
Approved Amounts*  Remainder of Medicare	\$0	\$0	\$[100] (Part B deductible)
Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
—Number of visits covered     (Must be received within 8     weeks of last Medicare     Approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

#### OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maxi- mum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

#### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[\*\* This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [\$1730] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [\$1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies	All Large Cl		
First 60 days 61 <sup>st</sup> thru 90th day 91 <sup>st</sup> day and after: —While using 60 lifetime	All but \$[912] All but \$[228] a day	\$[912] (Part A deductible) \$[228] a day	\$0 \$0
reserve days  —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
—Beyond the additional 365 days  SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days	\$0	\$0	All costs
21 <sup>st</sup> thru 100th day 101st day and after	All approved amounts All but \$[114] a day \$0	\$0 Up to \$[114] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

<sup>\*\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[\*\*This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [\$1730] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [\$1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

		[AFTER YOU PAY \$[1730] DEDUCTIBLE,**]	[IN ADDITION TO \$[1730] DEDUCTIBLE,**]
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE			
Available as long as your doctor	All but very limited		
certifies you are terminally ill and you	coinsurance for out-		
elect to receive these services	patient drugs and inpatient respite care	\$0	Balance
MEDICAL EXPENSES—IN OR	inpatient respite care	φυ	Dalatice
OUT OF THE HOSPITAL AND			
OUTPATIENT HOSPITAL			
TREATMENT, such as physician's			
services, inpatient and outpatient			
medical and surgical services and			
supplies, physical and speech therapy, diagnostic tests, durable			
medical equipment,			
First \$[100] of Medicare			
Approved Amounts*	\$0	\$[100] (Part B deductible)	\$0
Remainder of Medicare		,	
Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare Approved	<b>#</b> O	4000/	<b></b>
Amounts) BLOOD	\$0	100%	\$0
First 3 pints	\$0	All Costs	\$0
Next \$[100] of Medicare Approved	ΨΟ	7 til Oosto	ΨΟ
Amounts*	\$0	\$[100] (Part B deductible)	\$0
Remainder of Medicare Approved		,	
Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—TESTS FOR	1000/	<b>60</b>	0.0
DIAGNOSTIC SERVICES	100%	\$0	\$0

#### PARTS A & B

		AFTER YOU PAY \$[1730] DEDUCTIBLE,**	IN ADDITION TO \$[1730] DEDUCTIBLE,**
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED			
SERVICES			
—Medically necessary skilled care services and medical			
	100%	\$0	\$0
supplies —Durable medical equipment	100%	Φ0	<b>Φ</b> 0
First \$[100] of Medicare			
Approved Amounts*	\$0	\$[100] (Part B deductible)	\$0
Remainder of Medicare	Ψ	φ[100] (1 art Β deddottble)	Ψ
Approved Amounts	80%	20%	\$0
HOME HEALTH CARE (cont'd)			
AT-HOME RECOVERY			
SERVICES—NOT COVERED			
BY MEDICARE			
Home care certified by your doctor,			
for personal care during recovery			
from an injury or sickness for which			
Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	\$0	Actual charges to \$40	Balance
—Benefit for each visit	ΨΟ	a visit	Dalance
—Number of visits covered			
(Must be received within 8			
weeks of last Medicare			
Approved visit)	\$0	Up to the number of Medicare	
		Approved visits, not to exceed 7 each week	
		oxecos i oddii iiodii	
—Calendar year maximum	\$0	\$1,600	

# PARTS A & B

#### OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1730] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1730] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maxi- mum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

<sup>\*\*\*</sup>Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

#### **PLANK**

\* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (\*) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

#### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

\*\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[912]	\$[456](50% of Part A deductible)	\$[456](50% of Part A deductible)♦
61 <sup>st</sup> thru 90th day 91st day and after: —While using 60 lifetime	All but \$[228] a day	\$[228] a day	\$0
reserve days —Once lifetime reserve	All but \$[456] a day	\$[456] a day	\$0
days are used:  —Additional 365 days  —Beyond the additional	\$0	100% of Medicare eligible expenses	\$0***
365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[114] a day \$0	\$0 Up to \$[57] a day \$0	\$0 Up to \$[57] a day <b>♦</b> All costs
BLOOD First 3 pints Additional amounts	\$0 100%	50% \$0	50% <b>♦</b> \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out- patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

<sup>\*\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### **PLAN K**

#### MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\*\*\*\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$[100] of Medicare Approved Amounts****	\$0	\$0	\$[100] (Part B deductible)**** ◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4000])*
BLOOD First 3 pints Next \$[100] of Medicare Approved	\$0	50%	50%◆
Amounts****	\$0	\$0	\$[100] (Part B deductible)**** ◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ◆
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

<sup>\*</sup> This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

#### **PLAN K**

#### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies     —Durable medical equipment First \$[100] of Medicare Approved	100%	\$0	\$0
Amounts*****	\$0	\$0	\$[100] (Part B deductible) ♦
Remainder of Medicare			
Approved Amounts	80%	10%	10%♦

<sup>\*\*\*\*\*</sup>Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

#### PLAN L

\* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (\*) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

#### MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

\*\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and			
miscellaneous services and supplies			
First 60 days	All but \$[912]	\$[684] (75% of Part A deductible)	\$[228] (25% of Part A deductible)◆
61st thru 90th day 91st day and after: —While using 60 lifetime	All but \$[228] a day	\$[228] a day	\$0
reserve days  —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
<ul><li>Beyond the additional 365 days</li></ul>	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility Within 30 days after leaving the hospital			
First 20 days 21 <sup>st</sup> thru 100th day	All approved amounts All but \$[114] a day	\$0 Up to \$[85.50] a day	\$0 Up to \$[28.50] a day <b>♦</b>
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25% <b>♦</b> \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient	75% of coinsurance or	25% of coinsurance
	respite care	copayments	or copayments ♦

<sup>\*\*\*</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

#### **PLAN L**

#### MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\*\*\*\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
TREATMENT, such as Physician's services, inpatient and			
outpatient medical and surgical			
services and supplies, physical			
and speech therapy, diagnostic			
tests, durable medical equipment,			
First \$[100] of Medicare Approved Amounts****	\$0	\$0	\$[100] (Bort B
Approved Amounts	φ0	φ0	\$[100] (Part B deductible)**** ♦
Preventive Benefits for			deductible) •
Medicare covered services	Generally 75% or more	Remainder of Medicare	All costs above Medicare
	of Medicare approved	approved amounts	approved amounts
Demoinder of Medicers	amounts		
Remainder of Medicare Approved Amounts	Generally 80%	Conorally 15%	Generally 5% ♦
Part B Excess Charges	\$0	Generally 15%	All costs (and they do not
(Above Medicare Approved	ΨΟ	ΨΟ	count toward annual out-
Amounts)			of-pocket limit of
·			[\$2000])*
BLOOD			
First 3 pints	\$0	75%	25%♦
Next \$[100] of Medicare Approved Amounts****	\$0	\$0	\$[100] (Part B
, another	Ψ σ	Ψ σ	क्[100] (Pait B deductible) ♦
Remainder of Medicare Approved			,
Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY			
SERVICES—TESTS FOR	4000/	<b>*</b> 0	00
DIAGNOSTIC SERVICES	100%	\$0	(continued)

<sup>\*</sup> This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

#### PLAN L

# PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$[100] of Medicare Approved Amounts*****	100%	\$0 \$0	\$0 \$[100] (Part B deductible) ◆
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

<sup>\*\*\*\*\*</sup>Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.